

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2015
FORM APPROVED
OMB NO. 0938-0391

45th 9/05/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT VIEW OF ROCKY TOP			STREET ADDRESS, CITY, STATE, ZIP CODE 204 INDUSTRIAL PARK RD ROCKY TOP, TN 37769		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>A Recertification survey and investigation of complaints (#36197, #36203, and #36705) were completed on July 22, 2015, at Summit View of Rocky Top. No deficiencies were cited in relation to complaints (#36197, #36203, and #36705) under 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure a resident was assessed and approved to self-administer medications for 1 resident (#130) of 28 residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #130 was admitted to the facility on 7/14/15, with diagnoses including Pneumonia, Atrial Fibrillation, Chronic Pulmonary Heart Disease, and Chronic Respiratory Failure.</p> <p>Medical record review revealed no assessments had been completed to validate resident #130's ability to self-administer medications.</p> <p>Medical record review of Resident #130's</p>	F 176	<p>Unit Supervisor removed the respiratory inhaler from the room of resident #130. RN Supervisor and LPN Charge nurses conducted inspections of all resident rooms and no other medications were found. Nursing staff inservices are being conducted by the facility Staff Development Coordinator regarding the facility's policy and procedure regarding self-administration of medications to be completed by 8/17/2015. RN Supervisor will randomly inspect resident rooms 3 times per week for a total of 4 weeks to identify any medications in resident's possession. Findings will be reviewed by the Director of Nursing, who will also present findings to the QA Committee.</p>	8/17/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Robert L...

TITLE

Administrator

(X6) DATE

8/11/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT VIEW OF ROCKY TOP			STREET ADDRESS, CITY, STATE, ZIP CODE 204 INDUSTRIAL PARK RD ROCKY TOP, TN 37769		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 176	Continued From page 1 Physician's Orders for July 2015, revealed no orders for the resident to self-administer medications. Observation with Licensed Practical Nurse (LPN) #1 on 7/20/15, at 3:39 PM, in Resident #130's room, revealed no staff or the resident present, and a respiratory inhaler was on the over the bed table, available for the resident to use. Interview with LPN #1 on 7/20/15, at 3:41 PM, in Resident #130's room, confirmed the respiratory inhaler was on the over the bed table available for the resident to use. Continued interview confirmed no assessment to self-administer medications was completed for the resident, and no physician's order was obtained for the resident to self-administer medications.	F 176			